Why we need real and effective health care reform

By Congresswoman Jackie Speier (CA-12)
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Our current healthcare system is unsustainable. The rising cost of medical care, coupled with insurance companies' ever-expanding need to produce profits for their shareholders, have forced more and more Americans into the individual insurance market or - worse - to face life without medical coverage.

Healthcare reform will help those without insurance get it, but the most far-reaching impact of the legislation is what it does for the 80% of Americans who currently have coverage.

If you have medical insurance, you get it in one of three ways:

1. **A group policy**, provided by your employer, trade association or other group;
2. **An individual insurance policy**;
3. **A government-run policy**, such as Medicare, Medicaid or the Veterans Administration.

GROUP INSURANCE

Group policies through private insurance companies cover the majority of Americans and, according to recent polls, roughly half of those covered by group insurance are satisfied with their coverage. These people will be able to keep that coverage whether a health care reform package is passed or not. However, without healthcare reform, they cannot depend on it long-term. Here are a few reasons why this is true:

Rising Costs - The average family of four spent $7,000 per year on healthcare in 1994. That amount is over $13,000 now and is estimated to rise to $25,000 per year by 2019.[1] At this cost, few businesses will be able to afford covering their employees, subjecting them to added fees, increased co-pays and drastic reductions in benefits. Since 2008, 3.5 million Americans have been dropped from their group insurance policies, requiring them to buy an individual policy for their family (assuming none of them has a pre-existing condition), extend their current policy through expensive COBRA payments, or roll the dice and live without

[1] http://www.americanprogress.org/issues/2009/07/premiums_run_amok.html

insurance.[2] If you think this can't happen to you, think again. Every day, 2,190 Californians lose their group insurance coverage.[3]

Job Loss - As we have all witnessed over the past few years, no one's job is guaranteed forever. As devastating as the loss of a paycheck is to a family, it can turn catastrophic when coupled with being booted from group insurance. Only with real health care reform can families have peace of mind that, even if something as terrible as losing a job happens, they won't lose their access to health care.

Rescission - Since 2004, the three largest insurance companies have abruptly cancelled the policies of more than 20,000 Americans who did nothing more than fall seriously ill.[4] These are consumers who paid their premiums on time but due to the cost of their treatment, their insurance companies found it more cost-effective to have lawyers dig through the original application for an excuse to drop the customer than to pay for the medical treatment. A woman recently testified before the House Energy and Commerce Committee that her insurance policy was cancelled days before her mastectomy surgery because her insurer discovered that she didn't disclose on her application that she had once been treated for acne.[5]

INDIVIDUAL INSURANCE POLICY

If you have ever had to shop for insurance on the individual market, you know how difficult it is to find affordable coverage. The list of pre-existing conditions grows every day as insurance company actuaries insert themselves between patients and doctors to determine what will and will not be covered. Besides the aforementioned acne, pre-existing conditions that have been cited by insurers for denying care are as simple as heartburn, situational stress or having had a C-section. But these two stories take the cake:

Misdiagnosis - An Arizona woman was incorrectly diagnosed with bipolar disorder. It was soon corrected and her doctor confirmed that she never should have been diagnosed. Years later, she was turned down for an individual insurance policy due to her "psychological history" even though the only record of any psychological care was her misdiagnosis.

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[2] http://www.americanprogressaction.org/issues/2009/02/health_in_crisis.html
[3] http://www.americanprogressaction.org/issues/2009/03/pdf/health_losses.pdf
[4] http://energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf
[5] http://energycommerce.house.gov/Press_111/20090616/testimony_beaton.pdf

Too Healthy - A Florida man hadn't gone to a doctor since he was a child. He is an athlete who doesn't smoke or drink and believes that you only go to the doctor when you need one. But when he went shopping for an individual health policy, he was denied for "lack of current medical records." The man didn't have medical records because he never needed medical services, but as anyone knows who has tried to reason with an insurance company, his explanation fell on deaf ears.

GOVERNMENT-RUN POLICY

Currently, only a government sponsored plan such as one offered by Medicare, Medicaid or the Veterans Administration guarantees your care despite the cost or severity of any future affliction. Also, with a government plan, you need not fear being rejected for a pre-existing condition, being rescinded for a serious illness, or being dropped should you lose your job.

WHY IT BENEFITS ALL OF US TO INSURE THE UNINSURED

When those of us with insurance get sick or hurt, we go to our doctor. While there, the doctor might discover something that is an early indicator of another ailment and prescribe a preventative remedy or be able to treat the problem before it gets worse.

When someone without insurance gets sick or injured, they often do nothing until the problem festers into something more serious. At that point, they don't go to a doctor's office, because they don't have access to one. More likely, they seek help in the most costly place in the entire health care apparatus - the emergency room. Even more costly, they call 911, requiring an ambulance to transport them to the ER.

Because federal law mandates access to treatment regardless of ability to pay, uninsured individuals receive care that is paid for by the rest of us.[6] In 2008, of the $116 billion in care received by the uninsured, $42.7 billion was paid for by the insured in higher charges for health services. This practice, called "cost shifting", costs every American family with insurance more than $1,000 per year in increased premiums.[7]

The health care reform proposals being considered in Congress come with a

[6] http://www.cms.hhs.gov/emtala/
[7] http://www.familiesusa.org/resources/publications/reports/hidden-health-tax-findings.html

personal mandate that everyone have health insurance. Those who can pay must pay. Those that are too poor to pay will get help on a sliding scale up to the level of four times the poverty rate. When the more than 40 million currently uninsured Americans are able to visit a doctor, it will drastically reduce the demand on emergency services, allowing ER doctors and nurses to focus on real emergencies and letting firefighters and other first responders focus on their real jobs - protecting the citizens of their town or city.

Medical Debt - 62% of bankruptcies in the United States are caused by out-of-control medical debts. And three-quarters of those are from patients who had medical insurance when they fell ill.[8]

Standard of Care - Americans pay twice as much for healthcare as any other industrialized country - and our outcomes are worse. The United States ranks near the top in unnecessary deaths and our infant mortality rate is higher than all but 8 of the 37 most industrialized nations - below Cuba and Hungary. A large part of our healthcare cost is spent on things other than patient care. A recent study by the Congressional Budget Office concluded that 1/3 of the care provided in this country - around $700 billion per year - does not improve health.[9] And 20% of health insurance premiums go to overhead and profits (compared to just 5% in 1994).[10]

WHAT HEALTH CARE REFORM ACCOMPLISHES:

- Bans pre-existing conditions;
- Does away with rescissions;
- Disallows higher premiums based on gender, health status or occupation;
- Removes insurance companies' ability to selectively refuse to renew coverage.

In addition, the bill:

- Limits out-of-pocket expenses to stave off the 62% of bankruptcies caused by medical bills;[11]

[8] http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf
[9] http://www.cbo.gov/ftpdocs/95xx/doc9563/07-16-HealthReform.1.2.shtml
[10] http://content.healthaffairs.org/cgi/content/full/24/6/1629
[11] http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

- Provides consumer choice so Americans can keep the insurance they have if they like it or shop for a better deal through the Health Insurance Exchange (think: Travelocity for health care);
- Forces competition among providers so one or two insurance companies who control a given geographical area can no longer engage in bad customer service or jack up rates because their premium-payers have no other options;

WHAT I WANT TO IMPROVE IN THE CURRENT BILL

A Strong and Meaningful Public Option - Insurance companies, like all industries, are in business to make money and to maximize profits for their shareholders. That is the way our free-market system works. But without real competition from a public option, any reforms Congress might legislate will eventually be undone or circumvented by companies looking to shave costs to boost profits. It is absolutely essential that any public option be able to compete freely with private insurers and that its mandate be to provide the highest quality of care to the greatest number of people. The original draft of HR 3200 ties reimbursement rates for services to an existing public standard - what we pay for Medicare. However, an amendment in the Energy and Commerce Committee changed the formula to one more favorable to the insurance industry that, in effect, would allow the insurance companies to set the payment rates for the public option.

This will not guarantee true competition and will not serve to keep the costs of health care down. That is why I, and 56 of my colleagues in the House of Representatives, wrote a letter to Speaker Pelosi and the chairmen of the relevant committees stressing the importance of a true public option.

Affordable Coverage for All Americans - The current bill provides affordability credits for Americans who need help paying for health insurance coverage. The credits are highest for those just above Medicaid eligibility levels and are phased out when income reaches 400 percent of the federal poverty level ($43,000 for an individual or $88,000 for a family of four). However, amendments in the Energy and Commerce Committee placed a far heavier burden on the working poor, making their health care costs as high as 12% of total income.[12] In addition, those who do not qualify for subsidies could face daunting charges (a person making $45,000 could be required to pay almost $5,000 in health care premiums per year). I believe that these numbers need to be re-examined before we vote on a final bill.

[12] http://energycommerce.house.gov/Press_111/20090731/hr3200_ross_2.pdf

End Wasteful Expenditures - When in the state legislature, I authored a bill to limit self-referrals by physicians for services owned by them. This was in response to a study that showed that more than one billion dollars in unneeded health care costs were connected to self-referred services. Similarly, Congressman Stark authored legislation on the federal level banning Medicare reimbursement to physicians who refer patients for services and procedures in which they hold a financial interest. At the time, both laws contained an exception for in-office imaging, because no one wanted a patient with a broken arm to have to travel outside the doctor's office for a simple x-ray. However, since then, some private practices have abused this loophole by installing expensive - and extremely profitable - imaging machines such as CAT scans and MRIs.

The Government Accountability Office reports that imaging has ballooned into a $100 billion industry, costing taxpayers $14 billion per year in Medicare expenditures alone.[13] [14] In fact, imaging use has grown more than any other physician service within Medicare and 2/3 of advanced imaging takes place in-office. Making matters worse, recent studies show that 20%-50% of these scans do not help physicians diagnose ailments and as few as two or three CT scans can significantly increase a patient's likelihood of getting cancer.[15] [16]

I introduced HR 2962, the Integrity in Medical Imaging Act, to end this practice. Two representatives on the Energy and Commerce Committee, Rep. Anthony Weiner (NY) and Rep. Bruce Braley (IA), have committed to offering it in the form of an amendment to HR 3200 when we return to session this fall.

Healthcare Associated Infections - Healthcare reform promises to expand access to our country's hospitals and other healthcare institutions. With that, I am committed to ensuring that those hospitals will make patients better, not sicker. In particular, I am concerned about the rise in hospital acquired infections such as the super-bug - Methicillin-Resistant Staphylococcus Aureus (MRSA). According to the Centers for Disease Control, hospital acquired infections infect 1.7 million people each year, and 100,000 Americans die from these infections every year.[17]

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[13] http://www.gao.gov/new.items/d08452.pdf

[14] Colliver V. Curbing costs of medical scans: insurers seek to rein in fast-growing use of pricey high-tech MRIs and CTs. San Francisco Chronicle. April 24, 2005. Retrieved 8/07/09 from http://www.sfgate.com/cgi-bin/article.cgi?fi le=/c/a/2005/04/24/BUGD3CDRAP1.DTL.

[15] Dehn T, et al. Appropriateness of imaging examinations: current state and future approaches. Imaging Economics. March/April 2000. Retrieved 8/07/09 from http://www.imagingeconomics.com/issues/articles/2000-03_02.asp.

[16] Brenner D, Hall E. Computed tomography – an increasing source of radiation exposure. N Eng J Med. 2007;357:2277-2284.

[17] http://www.cdc.gov/ncidod/dhqp/hicpac_HHS_EffortsReduceHAI_textonly.html

The annual direct medical cost of these infections is as much as $45 billion[18] - money much better spent elsewhere.

I believe the approach to combating these infections within HR 3200 - calling for infection reporting and a government study - are inadequate. I am committed to doing all I can to ensure that these provisions are strengthened.

Pre-Existing Conditions - HR 3200 bans the insurance industry's practice of rescission immediately. I believe the same should be true for pre-existing conditions. Currently, this practice is not outlawed until the total bill takes effect in 2013. There is no reason why pre-existing conditions should not be done away with immediately and I hope the final bill reflects this change.

WHAT LIES AHEAD

On the last day of July, the House Energy and Commerce Committee became the last of three committees in the House of Representatives with jurisdiction over health care to pass HR 3200. (The Education and Labor Committee and Committee on Ways and Means passed the legislation earlier this summer.) In the Senate, two committees have jurisdiction - the Finance Committee and the Health, Education, Labor and Pensions (HELP) Committee.

During the August recess, the three House committees will combine their provisions into one bill that the House of Representatives will vote on in September. Meanwhile, the Senate will combine the work of their two committees into a finished product and Senators will vote on it sometime this fall. Once both chambers have approved the bills, Representatives and Senators will meet in a conference committee to resolve differences between the bills and emerge with a finished product. Because the Constitution requires that both chambers pass an identical piece of legislation before it can be signed by the President, Congress will vote once again on the bill that comes out of conference.

President Obama has called on Congress to pass a bill by this fall so he can sign it into law before the year's end. While I have some problems with the current bill and will insist on some changes before voting for its passage, I am confident that we can work together and pass a historic health care reform bill that will be signed into law by the President before Christmas.

[18] http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf

Even then, the work has just begun. As well-meaning and thoughtful as Members of Congress may try to be, most of us are not public health experts or hospital administrators. The bill calls for a new system to take effect in 2013 - leaving sufficient time to make sure it is done right and allowing time to fix any unforeseen problems that might arise.

Health care is something that affects all of us. Emotions are running high on this issue, but I have complete confidence that - should we pass a meaningful and effective health care reform package - America will soon have the kind of health care system that the greatest and most technologically advanced nation on earth deserves.